An independent investigation into the care and treatment of a mental health service user (Patient R) in Liverpool and surrounding area

January 2015

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1. EXECUTIVE SUMMARY

1.1 Niche Patient Safety was commissioned by NHS England in April 2014 to carry out an independent investigation into the care and treatment of patient R who pleaded guilty to the murder of T on 17 April 2011. T was robbed and murdered by R and one other in a Liverpool hotel.

1.2 R had a seven year history of contact with mental health and substance misuse services. He had inpatient admissions and community team follow up from two trusts: 5 Boroughs Partnership NHS Foundation Trust – referred to as Trust 1 in this report and Mersey Care NHS Trust – referred to as Trust 2 in this report.

1.3 He had also spent time in prison for a variety of offences. His last period in prison before the homicide was between September and November 2010 and his last admission to an acute inpatient unit was from 6 March to 15 March 2011.

1.4 Following the homicide the two trusts which had provided R's care and treatment carried out a joint internal investigation and made a number of recommendations:

- Medicines management and Acute Care pathway should be reviewed to ensure there is no contradiction in policy regarding the prescribing of medication on discharge;
- Practitioners should be reminded of the obligation to inform and update the safeguarding children's unit each time a patient with a previously recorded entry re-enters a service;
- Both trusts to engage with HMP Liverpool to explore ways to improve the communication and information sharing between them;
- Trust 1 should examine the clinical value of HoNOS[1] and reconsider the decision not to make HoNOS available on Otter[2];
- Trust 1 should introduce a specific risk assessment tool for the assessment of risk of violence and aggression/harm to others;
- Practitioners of patients in the community should take a more active role in helping individual patients secure a general practitioner;
- There is a need to improve the ward staff awareness of drug services available to them in the local community and
- Trust 1 should consider current inconsistencies of understanding and practice regarding the role and responsibilities of the 'named nurse'.

1.5 An action plan to implement these recommendations was also developed.

1.6 This independent investigation has reviewed the trusts' report, recommendations and action plan, and also looked in more detail at how services in Trust 1 have developed since 2011. Our findings are reported under the following headings:

- Mental health assessment;
- Risk behaviour and risk assessment;
- Medication;

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[1] *Health of the Nation Outcome Scales developed by the Royal College of Psychiatrists to measure the health and social functioning of people with severe mental illness.*

[2] *Trust 1's electronic mental health service data base.*

- Contact with addiction services;
- Communication between the two trusts;
- Social / family circumstances;
- Registration with a GP practice and
- Discharge planning.

1.7 Through this process we have considered whether there were any identifiable factors which could have caused or contributed to this tragic incident.
We found no specific **causal** factors. However the following **contributory** factors have been identified:

- A lack, at that time, of robust risk assessment and risk management processes for patients with personality disorder and/or drug dependence;
- No developed care pathway encompassing inpatient admission and community team intervention and follow up for such patients;
- R's diagnosis of personality disorder and his drug misuse;
- R's non-registration with a GP or registration with a GP in a different locality and
- R's lack of continuing engagement with the mental health service in Trust 1.

1.8 We also identified the following good practice:

- The community teams of both trusts and the DRR[3] team in Trust 2 made strenuous efforts to establish and maintain contact with R, with planned appointments, home visits, telephone calls, and letters;
- The assessing nurse in Trust 1 reported the alleged assault on R's sister to the police and recorded the log number and
- After all three admissions to acute inpatient wards there was community follow-up within seven days in accordance with Trust 1's policy[4].

1.9 There have been further recommendations arising from this independent investigation:

[3] *Drug Rehabilitation Requirements.*
[4] *5 Boroughs Partnership NHS Foundation Trust. Care Programme Approach. March 2010.*

Recommendations:

All of the recommendations set out in this report relate to 5 Boroughs Partnership NHS Foundation Trust (Trust 1). However recommendations 5 and 6 will also be of relevance to Mersey Care NHS Trust (Trust 2).

1. The Trust should provide training and develop guidance to ensure that there is a greater focus on, and value attached to, the building of a therapeutic relationship between inpatient and community staff and their service users.

2. The Trust should ensure that any reports from service users about violent behaviour are fully logged in the patient's notes and reported in detail to the police.

3. The Trust should ensure that, when there are reports of actual or possible violence, a detailed history is compiled and an appropriate risk assessment tool is used.

4. The Trust should ensure that their risk management strategy outlines a clear link between risk assessment, care planning, care co-ordination and the application of CPA.

5. The Trust should ensure that any requests for a specific medication are fully explored with the service user and the possibility of dependency is considered and discussed.

6. The Trust should consider whether, when a service user is known to have a particularly peripatetic lifestyle and there are significant concerns about risk, contact should be made with appropriate mental health trusts to share information (with due regard to guidance on confidentiality).

7. The Trust should ensure that, when there has been reported violence to a family member, there should be robust efforts to establish some contact with the victim and other family members to discuss the issue, and to consider an assessment of carers' needs, in line with Trust 1's CPA policy.

8. The Trust should review progress made against the internal review's recommendation for mental health staff to assist service users to register with a local GP, and establish systems for effective communication between GPs and mental health services regarding patient care.

9. The Trust should revise their drug detection policy to include procedures around the use of drug detection dogs, and specifically a process for making service users aware that drug detection dogs may visit acute inpatient areas.

10. The Trust should test for effectiveness their implementation of the internal investigation's recommendations, and ensure that the new model of care is operating fully and effectively by conducting some qualitative audits of the whole care pathway including for someone with personality disorder.

1.10 This report gives the findings of our investigation and the rationale for these recommendations.

2. INTRODUCTION

2.1 In April 2014 Niche Patient Safety was commissioned by NHS England, to conduct an independent investigation to examine the care and treatment of Patient R, a mental health service user who had received care from both 5 Boroughs Partnership NHS Foundation Trust and Mersey Care NHS Trust over the twelve months prior to the homicide. R had been convicted of the murder of T perpetrated in April 2011.

2.2 Under Department of Health guidance[5] such investigations are required when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

2.3 The terms of reference for this investigation are at Appendix A.

Independent investigation members

2.4 The investigation team were:

Sue Simmons, senior mental health nurse: (lead investigator and project manager)

Dr Ian Cumming, forensic consultant psychiatrist (peer reviewer)

Carol Rooney, senior investigations manager.

From this point the investigation team will be referred to in the first person plural.

2.5 The investigation team would like to extend their condolences to members of T's family.

2.6 We would also like to thank members of 5 Boroughs Partnership Foundation NHS Trust and Mersey Care NHS Trust for their help and co-operation during the course of this investigation.

[5] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*

3. THE APPROACH AND STRUCTURE OF THIS REPORT

3.1 Section 5 of this report sets out the details of the care and treatment of R. We have included a full chronology of his care at Appendix B in order to provide the context in which he was known to Trust services.

Section 6 examines the issues arising from R's care and treatment, and includes comment and analysis, while section 7 discusses good practice and contributory factors.

Section 8 reviews the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

Section 9 discusses the changes made in the 5 Boroughs Trust since 2011, while section 10 summarises the recommendations.

3.2 This investigation did not seek to re-investigate the case from the beginning, but to build on investigative work which had already taken place, using

- Clinical records
- Trust policies and procedures
- The Trust's internal investigation report
- The Trust's internal investigation archive

3.3 In addition the investigation team scrutinised health records, conducted interviews with key professionals and held a number of meetings. The review proceeded with reference to the National Patient Safety Agency (NPSA) guidance[6] and used a systematic process which looked beyond individuals and sought to understand the underlying system features and the environmental context in which the incident happened.

Records and reports

3.4 The team began by scrutinising the Trust's internal investigation report and appendices. Copies of R's mental health records covering approximately seven years were obtained. A chronology was developed and a more detailed timeline which recorded key aspects of R's care and treatment over the twelve months before the incident was devised. The main documents reviewed were:

- Mental health and addiction service records
- Computerised prison health records
- Trust 1's clinical policies and
- The internal investigation report, including statements and interview transcripts

Meetings

3.5 It was hoped to meet members of R's family and also the victim's family. In our meeting with R we asked for his agreement to meet or talk on the telephone to

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[6] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

members of his family. He agreed to follow up our meeting by letting us have a telephone number for his brother but in the event this did not happen. R told members of the internal investigation that there had been a serious revenge attack on his brother and his family had moved away from the Liverpool area.

3.6 We had no contact details for the victim's family. Therefore we liaised with the victim liaison officer who asked the family if they would like contact with us. Initially they agreed but did not respond to the two letters sent by Niche and NHS England in June and July 2014.

3.7 A meeting between R and the two members of the investigation team took place on 17 June 2014.

Interviews

3.8 There were interviews with:

- the main author of the internal investigation and
- 5 Boroughs Director of Nursing and the Consultant Clinical Psychologist who leads the personality disorder service.

These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.

Correspondence

3.9 There was correspondence with the victim liaison officer and manager and with a senior officer in Liverpool police service, to follow up particular queries.

Policies

3.10 A number of policies from 5 Boroughs Trust were reviewed. These are referenced at appropriate places in the report and included in the bibliography. In addition to the Trust's policies we have referred to relevant national policies and guidelines.

Analysis

3.11 The documents from these sources were then rigorously analysed to develop themes and findings, and in particular to identify factors which may have contributed to the incident. Wherever possible information was triangulated, that is checked against other sources for reliability. As far as possible we have endeavoured to eliminate or minimise hindsight or outcome bias[7] in this process. We have endeavoured to work with the information which was available to the trust at the time. However, where hindsight has informed some of our judgements we have identified this.

3.12 We would like to make it clear that no individual is criticised in this report.

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[7] *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident.*
Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

4. SUMMARY OF THE INCIDENT

Incident description (obtained from the internal investigation report and police records)

4.1 The homicide occurred in the early hours of 17 April 2011 in a small Liverpool hotel which was used on a long term basis by some occupants.

4.2 It appeared that R's girlfriend had been staying at this hotel, arranged by social services, for several weeks. The victim (T) had checked into the hotel on the afternoon of 16 April and was given a room next to R's girlfriend.

4.3 It was alleged that R and his girlfriend had been drinking in her room at the hotel that evening. T invited them into his room to drink with him, which they initially declined. R then went into T's room alone to ask him why he wanted to drink with them. T offered him a line of cocaine which he took. R and his partner then left the hotel to get more alcohol and when they returned they went into T's room to drink more alcohol and take cocaine.

4.4 T was killed in the early hours of the morning of 17 April 2011. He had received a very large number of separate injuries. He died from a trauma from a blunt instrument to his head.

4.5 Both R and his girlfriend were arrested in North Wales over 48 hours later. They were questioned and then charged with murder and robbery of a valuable watch belonging to T. R was assessed by the mental health criminal justice liaison team and was deemed fit to be interviewed and charged.

4.6 R pleaded guilty to the murder of T and received a prison sentence of 13 years.

5. CARE AND TREATMENT OF R

Brief history

This section has been compiled from the internal investigation and other reports in R's records.

5.1 R was born in July 1981 in the Huyton area of Liverpool where he spent his early childhood. He grew up with two sisters and three brothers. He has reported that he had a difficult childhood as a result of the violent behaviour of his father. Later his parents were divorced and R's father left the family home.

5.2 At the age of seven he was injured in a road traffic collision and received some compensation at 18.

5.3 R alleged that he was sexually abused at the age of nine by his older male cousin. Prison records indicate that this was reported to police many years later, but the outcome is not known. He left school after being expelled at the age of 12 and was later employed in several temporary labouring jobs. However, it appears that he has never had long term employment.

5.4 At the age of 23 years R discovered that his father was not his biological father and that he had half sisters and brothers. He then grew closer to his newly discovered family and began to distance himself more from the family he had grown up with. The relationship with his mother and her partner was extremely strained.

5.5 R had never married but had a number of relationships and two children with different mothers; a son born in 2005 living with his mother, and another son born in 2009 who was in the care of social services. R had no contact with either of his children. He reported that he had two uncles with schizophrenia and that his father was alcoholic.

5.6 R had a long history of alcohol and street drugs misuse, including cocaine, heroin, crack cocaine and ecstasy. He has reported that he began drinking alcohol at the age of 11 years and was using cannabis by the age of 12 and cocaine at the age of 14 years. In one assessment when he was in his twenties he said that he no longer took cannabis as he was 'already paranoid'. He confirmed in our meeting that he had not used cannabis since the age of 15.

5.7 There is some reference in his records to his family having trouble with gangs, and elsewhere he reported that one of his brothers had been shot and his mother's house firebombed several times.

5.8 During much of his adult life he used two different surnames at different times. 5 Boroughs Trust (Trust 1) and Mersey Care Trust (Trust 2) had records in different names; and in Mersey Care Trust this was not realised until August 2010 when his two sets of records were combined.

5.9 Prior to the homicide it is believed that he was living in his mother's house in Toxteth.

Forensic history

5.10 R had a significant forensic history, with convictions for a range of different offences. It appears that he had nineteen criminal convictions prior to the homicide, his first having been for being drunk and disorderly in 1997, at age 16. Offences have included theft, burglary, and criminal damage, possession of an offensive weapon, public order act offences, driving while disqualified, domestic violence, and assault.

5.11 The following list was compiled from a letter from the Trust 2 criminal justice mental health liaison team to the Liverpool crisis resolution and home treatment (CRHT) team in August 2010 and a memo from Trust 1 Criminal Justice Liaison Team on 29 March 2011.

1997	Drunk and disorderly	Caution
July 99	Burglary and theft	Community rehabilitation order (CRO)
August 99	Theft of moped and three fire extinguishers	Caution
March 2000	Taking a conveyance without consent, stealing a motorcycle and breach of CRO	Disqualification and 28 days in young offenders' institution.
Sept 2001	Breach of CRO	CRO continued and fine of £50
Oct 2001	Criminal damage and failure to surrender to custody	12 months CRO and 6 month curfew order, later revoked and changed to 28 days imprisonment
April 2002	Driving whilst disqualified	3 months imprisonment to run concurrently with sentence above
Feb 2003	Possessing an offensive weapon	4 months in prison
Feb 2006	Burglary with intent to steal,	3 years in prison
May 2006	A assault on his partner and their two year old son	15 months in prison (which ran consecutively with sentence above)
Feb 2009	Criminal damage	£200 fine and £100 compensation
Aug 2009	Theft (shoplifting)	12 months community order and 9 months drug rehabilitation. £100 costs.
Jan 2010	Burglary and theft	13 weeks imprisonment
April 2010	Criminal damage	Criminal damage. Fined £75 and ordered to pay £85.
June 2010	Failure to surrender to custody	12 months community order and 9 month drug rehabilitation order
July 2010	Disorderly behaviour	Fixed penalty notice
Sept 2010	Burglary with intent to steal	Imprisonment 4 months
Nov 2010	Theft from shop	Imprisonment 7 days
Dec 2010	Threatening behaviour	Fine
Jan 2011	Failure to comply with a community order	

5.12 The most significant of these convictions was in 2006 when he received a custodial sentence at Liverpool crown court for assault on his partner and child, and burglary with intent to steal, for which he received sentences totalling four years and three months.

5.13 It appears from prison health records that he had extensive contact with health and drug dependency services whilst in prison.

Summary of R's care from May 2010 to March 2011

5.14 R received care and treatment from two mental health trusts during the 12 months before the homicide: 5 Boroughs Partnership NHS Foundation Trust (Trust 1 in this report), and Mersey Care NHS Trust (Trust 2 in this report). There was a chaotic pattern to his contacts and it appears that he did not fully engage with any particular service.

Contact with Trust 2's addiction service

5.15 In June 2010 he was given a second drug rehabilitation requirement (DRR)[8] order for 12 months. In July he was reviewed by the staff grade psychiatrist and two members of Liverpool Drug Intervention Programme (DIP[9]) team. The plan was to increase his methadone prescription and for him to see his GP for psychotropic medication and to contact the crisis team at Royal Liverpool University Hospital (RLUH) if needed.

5.16 From 10 September to 9 November he was in prison for burglary

5.17 On 19 November R told his DRR worker that he would be moving to another area of Liverpool and he had his final appointment with Liverpool DRR team. He reported that he had been using heroin as he 'had lost his script (sic) (for methadone) last week'. He was advised to attend Sefton DRR team[10] the next day. His case was closed at Liverpool DRR team and there are no further records of any attendance at drug services.

Attendances at A&E

5.18 R presented at the accident and emergency (A&E) departments in Whiston and Liverpool on six different dates during this period. On three of these occasions he was admitted to an admission ward, and on the other occasions the plan was for him to be followed up by community teams.

5.19 In June 2010 he attended Whiston Hospital A&E, saying he felt he would explode and could hurt himself or others. He was admitted to Bridge ward[11] and later transferred to Coniston ward[12] from where he was discharged five days later.

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[8] *Drug Rehabilitation Requirements (DRR)*
These are part of a community sentence. They are a key way for offenders to address problem drug use and how it affects them and others. A DRR lasts between six months and three years.

[9] *The Drug Intervention Programme was a department within the Liverpool Criminal Justice Liaison Team. In 2003 the Home Office set up DIP schemes to use the criminal justice system as a means to enable offenders to address their drug misuse, at the same time as ensuring they were closely managed and connected to other services in order to reduce drug related offending.*

[10] *It is recorded in the internal investigation that the service in Sefton was at that time provided by the Crime Reduction Initiative, a national social care and health charity working with individuals, families and communities affected by drugs, alcohol, crime, homelessness, domestic abuse and antisocial behaviour.*

[11] *Bridge ward is an acute inpatient ward for men in the Halton area and is run by Trust 1.*

[12] *Coniston ward is an acute inpatient ward for men in the Knowsley area, and is run by Trust 1.*

5.20 On the same day as his assessment by the Liverpool DIP team in July 2010, R telephoned the mental health crisis line at RLUH. He told the member of staff he had been in Whiston Hospital recently but did not now have any medication and that he could not get medication as he did not have a GP. He was advised that he needed to register with a local GP from his new address.

5.21 In August he presented at A&E at RLUH saying he had had a psychotic episode and reported auditory and visual hallucinations. He was to be assessed by a mental health practitioner but did not stay in the department for assessment.

5.22 Later in August he was admitted to Park unit (an acute inpatient ward run by Mersey Care) where he stayed for four days.

5.23 On 6 September 2010 R attended A&E at Whiston Hospital saying he had taken an overdose of 16 citalopram[13], six quetiapine[14] and a number of mirtazapine[15]. (Blood results were reported as normal.) He also said he felt very depressed and was hearing voices telling him to hurt people and self-harm. He reported that he had assaulted three strangers in the street over the past week and was scared that he may kill someone. On further assessment it was agreed that he was not psychotic or depressed and he was not admitted, but was to be followed up by the community team.

5.24 In January 2011 R once again attended Whiston Hospital A&E. On this occasion the plan was to admit him, but there was no bed available. There was no record of attempts to find a bed in another service or a private bed via commissioners. He was therefore to be monitored daily by the Trust 1 CRHT team.

5.25 Following these admissions and two of his attendances at A&E he was followed up by the trusts' crisis resolution and home treatment teams who were able to make one or two initial contacts, by visiting him at his home address. Discussions on these visits often focused on access to medication and the need for him to register with a local GP. These initial contacts were followed by a series of attempted visits, in some cases team members visiting twice or three times in a day. The teams found that they were not able to see or speak to him and after between ten and fourteen days he was discharged from the teams' care and sent a discharge letter.
During these admissions R's status was that he was on the care programme approach (CPA). It appears from records that he was taken off CPA when discharged from the care of the community team.

R's last admission to Trust 1 acute inpatient care

5.26 On 5 March 2011 R presented again at Whiston Hospital A&E. He was seen for three separate assessments, by a specialist registrar, a senior house officer, and

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[13] *Citalopram is an antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) class. http://en.wikipedia.org/wiki/Citalopram*

[14] *Quetiapine is a short-acting atypical antipsychotic approved for the treatment of schizophrenia, bipolar disorder, and along with an antidepressant to treat major depressive disorder. http://en.wikipedia.org/wiki/Quetiapine*

[15] *Mirtazapine is a noradrenergic and specific serotonergic antidepressant (NaSSA) that was introduced in the United States in 1996 and is used primarily in the treatment of depression. http://en.wikipedia.org/wiki/Mirtazapine*

a member of the CRHT team. He complained of post-traumatic stress disorder[16], '*split personality*', and intrusive thoughts about harming others, that he was '*like an animal and would attack anyone on minor things'*. He said he could '*snap and kill anyone by battering them with a hammer'* and that he had strangled his sister until she passed out the day before. He requested medication and reported that he had had no medication since leaving prison in November 2010. R denied any hallucinations. The working diagnosis was '*worsening of psychosis, non-compliance with medication. High risk of harm to self or others*'. It was also noted that he appeared to have attended A&E in order to gain hospital admission and would benefit from assessment.

5.27 R was initially admitted to Bridge ward on CPA and two days later transferred to Coniston ward. The diagnoses on the admission particulars were:

- anxiety and depression
- personality disorder

5.28 Before his transfer to Coniston ward the Bridge ward team recorded that he appeared calmer with no obvious signs of agitation, psychosis, depression or anxiety. A drug screen was positive for cocaine. R said he was keen to have a psychological assessment. The team agreed a possible diagnosis of personality disorder, antisocial type, and considered a referral to the personality disorder hub.

5.29 At a multi-disciplinary review on 10 March 2011 on Coniston ward he told staff that he had taken cocaine and methadone recently. It was noted in the review record that he had appeared relaxed since admission, and that there were no thoughts of self harm or harm to others.

5.30 The plan arising from this review was:

- Continue medication
- Referral to personality disorder hub
- Staff to use cognitive behaviour therapy principles
- Can have leave off the ward, with staff having high index of suspicion about drugs
- Aim for discharge Monday or Tuesday (ie 14 or 15 March)
- Community psychiatric nurse (CPN) to contact mother to check history and enquire about alleged assault on sister

5.31 Over the next few days R had visits from members of his family and went off the ward with visitors on occasion.

5.32 On 15 March during the afternoon, a meeting was held with all patients to say that '*no leave would be allowed for informal patients'* as the drug detection dogs would be on the ward. It was recorded that R became verbally abusive, and de-escalation was needed. He asked to take his own discharge and refused to wait

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[16] *Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events. http://www.nhs.uk/conditions/post-traumatic-stress-disorder/Pages/Introduction.aspx*

to see the doctor. He left the ward with no medication. A risk screen was completed.

5.33 This risk screen recorded the following factors which could be relevant in the risk of harm to others:

- History of attempting or succeeding in harming others;
- Evidence that family members may be in danger from him;
- Feeling of hopelessness/helplessness;
- History of non-concordance with medication;
- History of disengaging from services;
- At risk if loses contact with services and
- It was judged that there was a likelihood of risk occurring to himself and to others.

5.34 As with previous admissions R was to be followed up by the CRHT team. The last contact between R and the team was on 17 March 2011 when they made a visit to his mother's home. The agreement was that the team members would check whether there was any medication for him on Coniston ward and visit the next day, but in the event he did not answer the door the next day and did not respond to further telephone calls or letters.

5.35 There was no further contact with either trust prior to the homicide on 17 April 2011.

6. ISSUES ARISING, COMMENT AND ANALYSIS

In this section we will focus on addressing this investigation's terms of reference concerning:

- care, treatment and services;
- care planning;
- risk assessment and management and
- adherence to local and national policies and guidelines.

6.A Mental health assessment

6.A.1 It is clear that R was someone who had a very chaotic lifestyle, and that this was partially recognised by mental health services. He had a seven year history of involvement with mental health services and latterly had repeated emergency admissions to inpatient or crisis team care when he was asking for help to manage his violent and disturbing feelings. Throughout his contact with mental health services he had great difficulty in continuing any engagement with services or was unwilling to engage.

6.A.2 There was a regular pattern of behaviour once he was admitted to inpatient care. He demonstrated no signs of distress or agitation, and appeared to be calm and friendly. One record noted '*No evidence of psychosis, depression or anxiety'*. He had a fairly consistent diagnosis of personality disorder and drug abuse, although when assessed in an emergency situation the possibility of psychosis, post-traumatic stress disorder (PTSD) or an anxiety state were also considered. His admissions were all fairly short as it was noted that he did not appear to need to be in hospital after the first few days.

6.A.3 On R's last admission in March 2011 the care plan drawn up on Bridge ward was not amended or apparently reviewed on his transfer to Coniston ward.

6.A.4 On R's third day on Coniston unit (10 March) he attended a multi-disciplinary review, which was his first meeting with his consultant. He told the meeting that he had taken cocaine and methadone recently. He also said he would return to his mother's house and that his brain was too active and he had sick thoughts of wanting to hurt others.

6.A.5 The meeting noted that he had appeared relaxed since admission, and that it appeared that there were no thoughts of self-harm or harm to others. There was no information gathered from nursing one-to-one sessions.

6.A.6 The plan drawn up by the multi-disciplinary meeting was to:

- Continue medication;
- Referral to personality disorder (PD) hub;
- Staff to use cognitive behaviour therapy principles;
- Can have leave off the ward, with staff having high index of suspicion about drugs;
- Aim for discharge Monday or Tuesday (ie 14 or 15 March) and
- CPN to contact mother to check history and enquire about alleged assault on sister.

6.A.7 It was not clear who was asked to make the referral to the PD hub and it appears that a referral was not made, although it was explored after his discharge. It appears that R did not give permission for staff to have contact with his mother, so it was deemed not to be possible for the CPN to check his history or enquire about the alleged assault on his sister. (This issue is discussed further in section 6.F.)

6.A.8 There was a similar pattern to his contacts with community teams, including the CRHT teams in both trusts. He had one or two contacts with them and then would drop out of contact, not responding to their visits or calls. Shortly after this loss of contact he would be discharged from their care.

6.A.9 We understand that the internal investigation was told by the community mental health team (CMHT) in Trust 1 that there was an open referral to the personality disorder hub after his self-discharge from Coniston ward. We have not been able to verify this from the records. However, there was an email from a member of nursing staff on Coniston unit to the CMHT on 29 March 2011 which commented that R was 'open to' the CMHT on Otter (the mental health service data base) and asked if someone from the team could discuss the possibility of a referral with R himself and the team leader of the PD hub, and possibly complete the referral. The email stated that an electronic referral had been made, but that "the team required a paper referral as well". The CMHT team leader then emailed a member of staff in the PD hub on 31 March 2011 to request a discussion, but there are no copies of referrals on file and no further notes on this matter.

6.A.10 There was also little acknowledgement within Trust 1 of the interaction between his mental health diagnosis and his drug abuse. On one occasion a psychiatrist recorded that his mental health difficulties were compounded by his drug abuse but there was little or no attempt to explore this further through psychological intervention or other therapy.

Comment

6.A.11 There were thorough assessments of his psychiatric history, mental state and current situation in the assessments carried out in A&E and on his admission in March 2011 to the ward in Trust 1. However these assessments and the consequent diagnoses did not appear to lead to an individual, person-centred care plan.

6.A.12

The NICE guidance on antisocial personality disorder[17] states that when considering possible antisocial PD the following should be assessed:

- Antisocial behaviours
- Personality functioning, coping strategies, strengths and vulnerabilities
- Co-morbid mental disorders (including depression and anxiety, drug or
- alcohol misuse, post-traumatic stress disorder and other personality disorders)
- The need for psychological treatment, social care and support and
- occupational rehabilitation or development

[17] *NICE (2014) Assessment and risk management for antisocial personality disorder.*

- Domestic violence and abuse.

It is striking that all of these were features of R's history or current situation.

6.A.13 Despite a variable diagnosis of personality disorder (PD) it appears that little attention was paid by inpatient or community teams to relevant NICE guidance or other guidelines. The Department of Health (DH) has estimated that between 40% and 50% of psychiatric in-patients are thought to meet the criteria for PD and the document goes on to state that:

People with PD often have a complex range of problems and needs, and they may be involved with a number of different agencies. However, their PD may affect their ability to benefit from services. Without the right kind of help and support, their problems are likely to continue, affecting not only their own well-being but also that of society in general.[18]

6.A.14 In addition the DH guidance goes on to comment on the importance of case management (or care co-ordination) in having a positive effect on individuals and systems as it 'holds clients through the care pathway and maintains relationships with other agencies and services.'[19] Further, it argues that engagement is key to success as people with PD may be suspicious, mistrustful and difficult to engage.

6.A.15 The Department of Health has acknowledged the significance of the relationship between a diagnosis of personality disorder and drug misuse and made ten recommendations for best practice in personality disorder services, generic mental health services and drug services. These are included in this report at appendix C.

6.A.16 In our judgement these guidelines describe the best possible practice which could be delivered with additional resources, probably with the input of a specialist team. They do not fully reflect the challenges and constraints facing a busy inpatient ward and the challenges presented by someone with a personality disorder on a mixed acute ward. This should be borne in mind in relation to our comments on any shortcomings in the service provided by Trust 1.

6.A.17 There was no clear plan to encourage R's engagement by, for example, one person attempting to develop a relationship / therapeutic alliance. Instead there appears to have been a focus on paperwork and risk assessment rather than really getting to know him and his issues. In addition there were no records of planned one-to-one time between his named nurse and R during his admissions to wards in Trust 1. The issue of the importance of a therapeutic relationship has been briefly referred to in Trust 1's Acute Care Pathway proposals[20], its Care Programme Approach policy and its named nurse guidance[21]. This guidance sets out the roles and responsibilities of the named nurse, including 'informing the service user about the frequency and duration of purposeful engagement

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[18] *Dept of Health (2009). Recognising complexity: Commissioning guidance for personality disorder services.*

[19] *Dept of Health (2009). Recognising complexity: Commissioning guidance for personality disorder services.*

[20] *5 Boroughs. (Sept 2011) Adult Acute Care Pathway.*

[21] *5 Boroughs Partnership NHS Foundation Trust (2012) Best Practice Guidance for Named Nurse (Adult In-Patient Services)*

sessions which should take place at least twice a week, and the development with the service user of a care plan.'

6.A.18 When we met R in prison he told us that he has only ever trusted one person and that was a prison officer who used to talk to him. From our scrutiny of prison records we think this may have been a nurse member of prison healthcare staff in HMP Liverpool, who appeared to have been developing a therapeutic relationship with him within which his allegations of childhood abuse were being explored. This was prevented from developing further by his release from prison in 2009.

6.A.19 The recommendations set out in this report relate to 5 Boroughs Partnership NHS Foundation Trust (Trust 1). However a number will also be of relevance to Mersey Care NHS Trust (Trust 2).

Recommendation 1
The Trust should provide training and develop guidance to ensure that there is a greater focus on, and value attached to, the building of a therapeutic relationship between inpatient and community staff and their service users.

6.B Risk behaviour and risk assessment

'*Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes*.'[22]

The following table sets out some of R's self-reported risk behaviours and risk assessments during the ten months prior to the homicide.

6/6/10 Presented at Whiston Hospital A&E, saying he felt he would explode and could hurt himself or others. Admitted to Bridge ward.

6/6/10 Assessed by psychiatrist on Bridge ward. The following risk assessment was made:

Risk to self (suicide/DSH) moderate to high
Risk to others → high due to violent thoughts and past history of assaults.

Risk screening also carried out. Risk to self and risk to others both assessed as likely to occur.

24/8/10 Risk assessment and management plan completed in Trust 2 service. The care/management plan included team visits to his home every second day in the first instance.
Risk to self assessed as low
Risk of self neglect – low to moderate
Risk to others – low.

6/9/10 Attended A&E at Royal Liverpool University Hospital (RLUH) - said he felt very depressed and was hearing voices telling him to hurt people and self-harm. Told mental health practitioner that he

[22] *DH (2008) Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*

	had assaulted three strangers in the street over the past week and was scared that he may kill someone. Further assessment the following morning, but not admitted.
29/1/11	Presented at Whiston Hospital A&E saying that he had violent thoughts that he would hurt someone, and that his heart was pounding. Said that his brother had been shot and his mother's house petrol bombed in the past. Plan was to admit to stabilise mental state and re-start medication, but no bed available. SHO's assessment was a moderate risk of harm to self and low risk of harm to others. Risk screening completed and it was judged that there was no likelihood of risk to himself or others occurring.
5/3/11 20.20 hrs	Presented at Whiston Hospital A&E. Seen first by Specialist Registrar complaining of PTSD and 'split personality' (R's comment). Last contact with mental health services three weeks ago. Intrusive thoughts about harming others. Said he strangled his sister until she passed out yesterday.
5/3/11 11.40 hrs	Second assessment by SHO and CPN in A&E. Said that mental health had deteriorated over past few weeks. Said that he was 'like an animal and would attack anyone on minor things.' Again reported that he had strangled his sister. Denied any hallucinations. 'High risk of harm to self or others'.
06/3/11	Comprehensive assessment (third assessment on this presentation at A&E) completed by nurse practitioner in CRHT team. Reported that he said his mental state had deteriorated since leaving prison in Nov 2010. Said he could 'snap and kill anyone by battering them with a hammer'.
6/3/11	HoNOS[23] scores completed by admitting nurse, who scored risk of harm to others as very severe. Admitting nurse also assessed risk of recurrence of aggressive and violent behaviour from R was low, on basis that R had accepted admission, he was pleasant and behaved appropriately, and he was not hostile to staff. In addition admission had removed R from contact with his sister. If he had been in the community the nurse would have rated the risks higher. Told staff on the ward that he had been taking heroin, methadone and cocaine approximately six months ago.
10/3/11	Told CPN that his brain was too active and he had sick thoughts of wanting to hurt others. Noted in the review record that he had appeared relaxed since admission, and that there were no thoughts of self-harm or harm to others. No further risk assessment or plan.
15/3/11	R asked to take his own discharge and refused to wait to see the doctor. Risk screening completed. The screen recorded the following factors which could be relevant in the risk of harm to others:

[23] *Health of the Nation Outcome Scales developed by the Royal College of Psychiatrists to measure the health and social functioning of people with severe mental illness.*

- History of attempting or succeeding in harming others
- Evidence that family members may be in danger from him
- Feeling of hopelessness/helplessness
- History of non-concordance with medication
- History of disengaging from services
- At risk if loses contact with services

It was judged that there was a likelihood of risk occurring to himself and to others.

6.B.1 It is clear from this list that R himself reported that he had either already assaulted others or that he was worried that he would do so, and that he was asking for help to prevent this. However the assessments of risk of violence to others were quite variable.

6.B.2 There was no log of actual or reported violent or aggressive incidents or any use of a specific risk assessment tool designed for the assessment of risk of violence to others, for example the HCR-20[24]. Trust 1's Clinical Risk Assessment Policy[25] states that the two standard risk assessment tools are the Risk Screening Tool which should be used at initial contact by front-line staff and the Main Risk Assessment Tool which was designed to be more detailed and to be used by any member of staff acting in a care co-ordinator role. However at the time of his assessment for admission in March 2011 there were short entries on risk as part of the overall documentation, but no use of these specific risk documents. During his admission there was no record of the use of the Main Risk Assessment Tool and only one record of the Risk Screening Tool at the time of his discharge. This screening tool concluded that there was a likelihood of risk to himself or others. However this did not appear to prompt the use of the more detailed Main Risk Assessment Tool.

6.B.3 There is a report on file that nursing staff reported R's attempt to strangle his sister to the police and the matter was logged. The log number was recorded in R's mental health records. When we asked the Liverpool police to give us further information about this log we were told that it related to a request for help to transfer R to the ward, but that it also made reference to some disclosures which had prompted this transfer. They were unable to give us any further information.

Comment

6.B.4 *'The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred.'*[26]

6.B.5 The NICE guidance on anti-social personality disorder[27] comments on the need for a comprehensive risk management plan based upon a detailed history of violence and contact with the criminal justice system. A Department of Health

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[24] *The HCR-20 is a comprehensive set of professional guidelines / risk assessment tool for the assessment and management of violence risk. It focuses on 20 factors: 10 historical (H), 5 clinical (C), 5 risk management (R)*
[25] *5 Boroughs Partnership NHS Foundation Trust. 2011. Clinical Risk Assessment Policy.*
[26] *Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23.*
[27] *NICE (2014) Assessment and risk management for antisocial personality disorder.*

document on risk in mental health services comments that 'risk management requires an organisational strategy as well as efforts by the individual practitioner.'[28] There was no comprehensive history in one place in R's records. This may have been a reflection of the fact that the diagnosis of personality disorder was not consistent.

6.B.6 There was no reference in Trust 1's risk assessment and management policy to any specific assessment tool for the risk of violence or aggression. However one of the recommendations arising from the internal investigation was that the trust should introduce such a tool. We are aware that a significant number of staff have been trained in the use of the HCR-20 assessment tool since 2011.

6.B.7 The link between risk assessment, care planning and the application of care co-ordination and the care programme approach (CPA)[29] was not clear.

6.B.8 It appears that there may have been some miscommunication between the police and the mental health service about R's reported attempted strangulation of his sister. The mental health professionals thought that they had reported this so that the police would take appropriate action. However the police log of this recorded it as 'disclosures' which prompted his transfer to hospital, rather than anything requiring investigation.

Recommendation 2
The Trust should ensure that any reports from service users about violent behaviour are fully logged in the patient's notes and reported in detail to the police.

Recommendation 3
The Trust should ensure that, when there are reports of actual or possible violence, a detailed history is compiled and an appropriate risk assessment tool is used.

Recommendation 4
The Trust should ensure that their risk management strategy outlines a clear link between risk assessment, care planning, care co-ordination and the application of CPA.

6.C Medication

6.C.1 There is a recurring theme in R's records of his requests to be prescribed quetiapine, and his assertions that he would hurt others or himself if he did not get it. It appears that he received quetiapine when he was in prison and when an inpatient but did not receive it when living in the community.

6.C.2 Quetiapine is an oral anti-psychotic medicine which is normally used to relieve the symptoms of schizophrenia, bipolar disorder, and other similar mental health problems. R was first prescribed quetiapine when in prison but it is not clear from his prison health records why or when it was first started. R told the internal

[28] *DH (2007) Best Practice in Managing Risk. This document refers to a number of risk assessment tools, including HCR-20.*
[29] *5 Boroughs Partnership NHS Trust. (2010) Care Programme Approach Policy.*

investigation that he had been diagnosed with psychosis when in prison but it has not been possible to verify this. Some specialists have reported that it is widely used in prison populations and sometimes referred to as 'jailhouse heroin'[30]. They have also suggested that there is the potential for misuse/abuse.

6.C.3 Instances of requests for quetiapine

6/6/10	Presented at Whiston Hospital A&E, saying he felt he would explode and could hurt himself or others. Admitted to Bridge ward. Asked to be prescribed quetiapine
7/6/10	Contact made by Bridge ward staff with his probation officer and drugs worker. Told that he had come out of prison in February 2010 and would have had two weeks of quetiapine (often prescribed as a sedative to help methadone users in prison). Repeatedly told staff that he felt his 'head would explode', and that quetiapine was the only medication which worked.
15/7/10	Late in the day R contacted A&E at RLUH. He reported that he had been in Whiston Hospital recently and been prescribed quetiapine and citalopram, but did not have any more as he was no longer registered with a GP. He was told that he would have to register with a GP from his new address.
30/1/11	Home visit by CRHT as no bed available for admission. Explained that citalopram could be started straight away, but quetiapine would need him to be registered with a GP. He became very angry, said that the citalopram did not work, and that he would not engage with team and asked them to leave.
3/2/11	Home visit by two members of CHRT team. R opened the door and let them in. Initially very angry but later calmed down. He told them the citalopram did not work. Staff said they would find out why he had not been prescribed quetiapine.
6/3/11 06.00 hrs	Admitted to Bridge ward from Whiston A&E and started on quetiapine and citalopram. Said that he had not been taking his medication since released from prison in Nov 10, as he had no GP.
7/3/11 am	72 hr post-admission review. Appeared calmer and no obvious sign of agitation. No evidence of psychosis, depression or anxiety. Said he needs medication to calm him down, and said that if he did not get it he would 'kick off'.

Comment

6.C.4 It does appear to be possible that he had developed some dependence on this medication and may even have sought admission in order to have it prescribed. It appears that this possible dependence was not explicitly recognised or explored by the Trust 1 inpatient team and his requests to go back on this medication were met.

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[30] *Sansone, RA &. Sansone, LA. Is Seroquel Developing an Illicit Reputation for Misuse/Abuse? Psychiatry (Edgmont). Jan 2010; 7(1): 13–16.http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848462*

Recommendation 5
The Trust should ensure that any requests for a specific medication are fully explored with the service user and the possibility of dependency is considered and discussed.

6.D. R's contact with drug services

6.D.1 For many years R was receiving care from the DRR team provided by Trust 2. At that time he used a different surname and it appears that it was not recorded that he was also known to Trust 1. His contact from September 2009 with the drug service, which was provided by the charity Addaction, was under the auspices of a Drug Rehabilitation Requirements (DRR) order. This nine month order was breached in March 2010 and he was discharged from the service. He was given a second DRR order for 12 months in June 2010, with the requirements that he attend weekly probation appointments and weekly drug service appointments for prescribing and weekly urine testing. He was prescribed methadone which appears to have been under supervised consumption. R attended many but not all his urine test appointments and his results were positive for methadone, opiates and cocaine. In November 2010 he told his drugs worker that he was moving to Sefton/Bootle and a faxed referral was sent to the Bootle service. A further letter was sent to his GP. It is not known whether he ever attended the Bootle addictions service, but it is known that he was charged with failure to comply with a community order (of which the DRR was part) in January 2011.

6.D.2 During both episodes of care he was prescribed methadone and on the second referral he was being considered for a rehabilitation programme. There were many recordings of the team's attempts to maintain contact with R over the months of his order. There were a number of meetings arranged between R, the DRR team and mental health services. At one point it appears that he was living in a hostel and the DRR team also liaised with hostel staff. Within the terms of the community order the staff appeared to make every effort to maintain therapeutic contact. They would, where possible, re-arrange meetings and inform and remind him of appointments.

6.D.3 R may not have seen himself as a user of Trust 2's addiction service. When we met him in 2014 he said that he had never been a client of the service but had been on probation, and it was in connection with this that he saw the addiction service staff.

6.D.4 When he was an inpatient in 2011 there was no discussion in the Coniston multi-disciplinary team about the possibility of referring him to the addiction service which covered the 5 Boroughs area. It appears that the team did not think there was any service as the previous service provided by Addaction had been withdrawn and the service was at that time being provided by another organisation.

6.D.5 After his self discharge R received a letter in April 2011 from the community mental health team offering him an appointment with a dual diagnosis worker, but

the letter did not explain what was meant by dual diagnosis (as this can have several meanings) or any possible benefits for him in seeing someone with this perspective.

Comment

6.D.6 It is clear within Trust 2's records that R received a great deal of input from the addiction service and that staff worked hard to provide appropriate care. It seems possible that he would not have engaged with the service at that time if it had been purely voluntary, rather than it being a part of a community order. There also appears to have been good liaison between the addiction service, the Trust 2 acute admission ward, and the community teams. However it appears that there was not enough recognition within Trust 1's mental health service of his drug problems and their links with his mental health problems, and little consideration given to whether liaison with local addiction services would have been appropriate. This may have been the result of less strong links between the mental health services and local addiction services.

6.D.7 In April 2011 it appears that Trust 1's community team was considering whether it would be helpful for R to have some contact with a dual diagnosis worker and a letter was sent to him offering him an appointment. It was unfortunate that this was not discussed with him while he was in hospital, prior to his discharge. He may have rejected such help but it is possible that he may have been willing to have some brief contact.

6.E Communication between the two trusts

6.E.1 There was little communication between the two Trusts involved in R's care and treatment. He received care from the DRR team provided by Trust 2 as a result of his DRR orders, but he also had contact with the mental health services of Trust 2 between July and September 2010.

6.E.2 At a meeting with members of staff of Trust 2's Drugs Intervention Programme on 15 July 2010 R was advised to contact A&E at the Royal Liverpool University Hospital (RLUH) if needed. Later that day R contacted the helpline and told the member of staff he had been in Whiston Hospital recently and been prescribed quetiapine and citalopram, but did not have any more as he was no longer registered with a GP. He was told that he would have to register with a GP from his new address.

6.E.3 On 9 August he attended A&E at RLUH in person saying he had had a psychotic episode and reported auditory and visual hallucinations. He was to be assessed by a mental health practitioner but did not stay in the department for that assessment.

6.E.4 On 19 August it appears that he had been able to register with a GP and this new GP was very concerned about his mental health and wanted him seen quickly. He was assessed by a senior house officer in A&E at RLUH and admission was agreed to Park unit (an acute inpatient ward run by Trust 2). He stayed on the ward until 23 August when he was discharged to be followed up by Trust 2's CRHT team who initially planned to visit every second day.

6.E.5 Shortly afterwards, on 6 September, R attended RLUH A&E again stating that he had taken an overdose of 16 citalopram, six quetiapine and a number of mirtazapine. He also said he felt very depressed and was hearing voices telling him to hurt people and self-harm. He was assessed by a mental health practitioner and told her that he had assaulted three strangers in the street over the past week and was scared that he may kill someone. There was a further assessment the following morning, but he was not admitted.

6.E.6 This episode of contact with A&E and the Trust 2 CRHT came to an end when he went into prison on 10 September 2010.

6.E.7 During the period of R's contact with Trust 2's mental health services, from 15 July to 10 September 2010, he did not have any contact with Trust 1 services and it appears that he had an address in Mersey Care's area. There was therefore no overlapping period during which both mental health services were involved.

6.E.8 There were, however, some periods of time when R was receiving care from both trusts (addiction service care from Trust 2 and mental health care from Trust 1). Despite this there were a small number of entries in records of contact between the two trusts. For example on 7 June 2010 a member of staff on Bridge ward (Trust 1) contacted R's probation officer and drugs worker (Trust 2). The member of staff was told that R had come out of prison on 25 February 2010 and would have had two weeks of quetiapine.

Comment

6.E.9 There appears to have been little communication and no joint working between the two trusts or between the addiction service and inpatient and community service.

Recommendation 6
The Trust should consider whether, when a service user is known to have a particularly peripatetic lifestyle and there are significant concerns about risk, contact should be made with appropriate mental health trusts to share information (with due regard to guidance on confidentiality).

6.F Social/family circumstances

6.F.1 R reported an unhappy childhood, abuse, exclusion from school, and involvement in criminal activity and the abuse of street drugs from a relatively early age. He had been unemployed for most of his adult life and moved frequently, sometimes living in hostels and at other times with his mother or grandmother. As he moved so frequently he often told staff that he did not have a GP.

6.F.2 There were two young sons but, in 2011, he had no contact with them or with their mothers. He had few stable relationships and there appears to have been family tension and conflict. He reported that he had seriously assaulted his sister. There was a clear picture of someone who had a chaotic life-style with few if any anchors or supports.

Comment

6.F.3 It appears that this chaotic life-style was recognised when he was admitted to hospital in 2010 and 2011, but there were few attempts to help him deal with it. There were no attempts to make any contact with his family, even when family members visited him in hospital in March 2011. It appears that the internal investigation was told that R had said that the CPN could talk to his mother but he wanted to talk to her first. He appears to have later told staff that he did this and his mother said that she did not want to talk to staff. However, in the light of the serious alleged assault on his sister, we believe that staff should have taken the initiative in making contact with his family.

6.F.4 When he discharged himself on 15 March 2011 he told staff that he planned to return to his mother's house. This was apparently also where his sister whom he had attempted to strangle lived. Again there was no contact made with his mother or sister prior to him leaving.

6.F.5 In our judgement the apparent seriousness of the alleged assault on his sister should have prompted exploration of the incident through discussion with his mother or other members of his family before his discharge, despite his report that his mother did not wish to talk to staff. This would have informed risk assessment and discharge planning.

Recommendation 7
The Trust should ensure that, when there has been reported violence to a family member, there should be robust efforts to establish some contact with the victim and other family members to discuss the issue, and to consider an assessment of carers' needs, in line with Trust 1's CPA policy.

6.G Registration with a GP practice

6.G.1 On admission to hospital it appears that R would sometimes tell staff that he was registered with a particular practice but that this was usually not the case. At other times he told staff that he did not have a GP. However, it appears, from records obtained for this investigation by the clinical commissioning group (CCG), that he was never unregistered or taken off a general practice list, but he was not necessarily living close to where he was registered. When the internal investigation team enquired into his registration with a GP they were told that it was unlikely that a GP practice in a city area would keep him on if he moved several miles away. As he moved frequently it seems likely that he would therefore often be, in effect, unregistered. His registration over the three years before the homicide was:

13 Oct 2008	Hamilton Medical Centre, 86 Market Street, Birkenhead
10 Feb 2009	Cross Lane Surgery, Whiston Primary Care Resource Centre, Old Colliery Road, Whiston
26 Oct 2009	Anfield Group Practice, Townsend Lane Health Centre, 98 Townsend Lane, Liverpool
5 Jul 2010	Abercromby Family Practice, Grove Street, Liverpool

6.G.2 On his last admission in March 2011 he told staff that he was registered with the Strand Medical Centre in Bootle. In fact it appears that he was still registered with Abercromby Family Practice. However there is a letter on file, sent to Abercromby Health Centre, and then returned from that health centre to say that he was not their patient.
There were numerous standardised letters in R's records to GPs, but no evidence of any further attempted dialogue between any GP and the mental health service.

Comment

6.G.3 The lack of effective communication with R's GP is of significance as many of the letters were informing the GP about R's discharge from the service and the plan to 'discharge back to the care of his GP'. He was also unable, on a number of occasions, to have quetiapine prescribed for him as he did not appear to have a current GP. Effective communication from the community teams would have been essential to maintain continuity of care. Further, despite R telling community teams in particular that he did not have a GP (as he believed) there does not appear to have been any offer to help him register.

Recommendation 8
The Trust should review progress made against the internal review's recommendation for mental health staff to assist service users to register with a local GP, and establish systems for effective communication between GPs and mental health services regarding patient care.

6.H Discharge planning

6.H.1 In January 2011, following his assessment in A&E, and in March 2011, following his short admission, R was to be followed up by the crisis resolution and home treatment (CRHT) team. In both instances home visits were conducted by two members of the team. There were one or two successful visits and a number of failed contacts, including when there was no answer at the door or no response to telephone calls. On many occasions the community team members attempted to contact him, leaving messages and visiting many times and at different times of the day, before he was discharged.

6.H.2 We do not know if the imminent arrival of drug detection dogs on the ward on 15 March 2011 influenced R's decision to discharge himself. We understand that this is a regular but not frequent occurrence. We cannot find reference to this practice in either the trust's Drug and Alcohol Policy[31] or in appendices to that policy (the Acceptable Behaviour Agreement and the Ward Notice on Illicit Drugs and Alcohol – zero tolerance).

6.H.3 When he discharged himself from Coniston ward in April 2011 he went back to his mother's house without any medication, as he left after the closure of the pharmacy. The internal investigation attempted to review whether the lack of medication was as a result of the unplanned nature of his discharge or whether those who take their own discharge are routinely not allowed to have medication.

[31] *5 Boroughs Partnership NHS Foundation Trust. (2011) Drug and Alcohol Management Policy.*

There is a recommendation about this in the internal report, which we have not repeated.

Comment

6.H.4 We believe there were significant attempts made to make contact. However in our view it would have been appropriate for the CMHT /CRHT to attempt to establish a relationship with him before his discharge so that he would know at least one of the people likely to visit.

6.H.5 We do not believe, in the light of his previous pattern of not engaging, that this would have necessarily prevented him dropping out of contact. However in our view an attempt to engage him in this way would have been best practice. This is now part of the operational policy described in the 2013 Adult Services Inpatient Model[32].

Recommendation 9
The Trust should revise their drug detection policy to include procedures around the use of drug detection dogs, and specifically a process for making service users aware that drug detection dogs may visit acute inpatient areas.

[32] *5 Boroughs Partnership NHS Foundation Trust. 2013. Adult Services Inpatient Model.*

7. CONTRIBUTORY FACTORS AND GOOD PRACTICE

7.1 Through this process we have considered whether there were any identifiable factors which could have caused or contributed to this tragic incident.

7.2 We found no specific **causal** factors. However the following **contributory** factors have been identified:

- A lack, at that time, of robust risk assessment and risk management processes for patients with personality disorder and/or drug dependence;
- No developed care pathway encompassing inpatient admission and community team intervention and follow up for such patients;
- R's diagnosis of personality disorder and his drug misuse;
- R's non-registration with a GP or registration with a GP in a different locality and
- R's lack of continuing engagement with the mental health service in Trust 1.

Good practice

7.3 We found that the community teams of both trusts and the DRR team in Trust 2 made strenuous efforts to establish and maintain contact with R, with planned appointments, home visits, telephone calls, and letters.

7.4 The assessing nurse in Trust 1 reported the alleged assault on R's sister to the police and recorded the log number in his notes.

7.5 After all three admissions to acute inpatient wards there was community follow-up within seven days in accordance with Trust 1's policy[33].

[33] *5 Boroughs Partnership NHS Foundation Trust. Care Programme Approach. March 2010.*

8. 5 BOROUGHS TRUST'S INTERNAL INVESTIGATION

8.1 In this section we shall address two further elements in the terms of reference of this independent investigation:

- Review the trust's internal investigation and assess the adequacy of the findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.

8.2 The internal investigation was carried out by a senior member of staff from each of the two trusts with the advisory, independent input of a third senior member of staff from another trust in the region.

8.3 The internal team explored a number of issues including: patient factors (including R's forensic history), diagnosis, medication, assessment of R's mental health, risk assessment, positive practice, and care planning and co-ordination.

8.4 Their analysis then focused on team issues, communication, education and training, working conditions, and organisational and strategic issues.

8.5 The following recommendations were made by the Trust's internal investigation

- Medicines management and Acute Care pathway should be reviewed to ensure there is no contradiction in policy regarding the prescribing of medication on discharge;

- Practitioners should be reminded of the obligation to inform and update the safeguarding children's unit each time a patient with a previously recorded entry re- enters a service;

- Both trusts to engage with HMP Liverpool to explore ways to improve the communication and information sharing between them;

- The trust should examine the clinical value of HoNOS and reconsider the decision not to make HoNOS available on Otter;

- The trust should introduce a specific risk assessment tool for the assessment of risk of violence and aggression/harm to others;

- Practitioners of patients in the community should take a more active role in helping individual patients secure a general practitioner;

- There is a need to improve the ward staff awareness of drug services available to them in the local community and

- The trust should consider current inconsistencies of understanding and practice regarding the role and responsibilities of the 'named nurse'.

Comment on the internal investigation from the independent investigation

8.6 The internal investigation was a thorough and comprehensive piece of work. We understand that the team felt they were well supported by the two trusts and were given the time and other resources needed. We were in accord with all the recommendations and have therefore not repeated them in this report. We have scrutinised the action plan arising from the internal report and reviewed the evidence of its implementation. In our judgement the action plan was appropriate and there has been good progress in implementing the recommendations.

8.7 The trust's action plan is at Appendix D.

9. THE 5 BOROUGHS SERVICE IN 2014

9.1 There have been a number of changes to the mental health services in Trust 1 since 2011, some of which are relevant to the findings of the internal investigation and this independent investigation. These developments are outlined in a number of strategy documents and some of the changes and pathways have been audited, both qualitatively and quantitatively. Rather than describe all the changes here we have focused on those which could have made a difference to the care provided to R in 2010-11.

9.2 The most significant and relevant of these changes are:

The further development of the personality disorder hub and spoke service.

9.3 In 2011 the PD hub was an assessment and training service. Over the past three years a large number of inpatient and community staff have received PD awareness training in line with the Knowledge and Understanding Framework (KUF)[34]. The inpatient staff training programme focused on awareness and understanding, so that staff who have completed it would be more compassionate and less judgemental. It is not known whether Coniston ward staff had received the training at the time of R's last admission.

9.4 As we have seen there had been some discussions about referring R to the service in 2011 but a full referral was not sent through to the service. If the referral had been received R would have received a letter explaining that he had been referred and offering him an appointment for assessment. His drug use would not have excluded him. It is quite possible that his chaotic lifestyle would have resulted in him not attending. However if he had attended the appointment for an assessment the PD team would have had the opportunity to offer advice, support and supervision to his care co-ordinator.

9.5 Since 2011 the service has developed further so that it now provides a PD care pathway including dialectic behaviour therapy (DBT) and mentalisation therapy, as well as supervision to a wide group of generic mental health staff. The recent inpatient care pathway[35] specifies that:
All service users who have a personality disorder and present associated risk will be allocated a care co-ordinator (before discharge). In all such cases, appropriate psychological therapy or psychological informed case management will be offered. The provision of psychological therapy will be prioritised for people who have entered the inpatient's care pathway. Consistency and reliability is the key to the success of the care plan whether the person is on the ward or in the community. The therapeutic alliance is a key to good outcomes.

9.6 It is possible that, if R had been referred to the service in 2014, that he would have been offered specific individual or group therapy. Much of the therapy would be offered by specially trained nurse practitioners who are based within recovery teams. However the philosophy of the PD service is that the pathway is a

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[34] KUF is a national framework to support people to work more effectively with personality disorder. It was commissioned by the Dept of Health and the Ministry of Justice in 2007.
http://www.personalitydisorder.org.uk/training/kuf
[35] 5 Boroughs Partnership NHS Foundation Trust. Severe Personality Disorder Care Pathway - Adult Inpatient Services

partnership between the service and the service user which requires the service user's active participation and involvement. The lead clinician of the PD service told us that pathways for people with antisocial personality disorder have not yet been developed and he was somewhat doubtful, based on what is known about R's use of the mental health service in 2011, whether he would have engaged with the service.

9.7 There has also been the development of a new inpatient model of care[36] which incorporates a PD pathway. This new approach also focuses on purposeful admission for all and a recovery focus which encompasses inpatient and community care. This work has been piloted and positively evaluated in one of Trust 1's inpatient wards.

9.8 If R were to have been admitted to an inpatient ward in 2014, this new model could have led to the much earlier involvement of the dual diagnosis worker, a member of the community mental health team, during his admission.

9.9 There has also been the introduction of a new group supervision initiative for inpatient nursing staff. Inpatient matrons have the lead for the facilitation and monitoring of this programme. At the same time the way in which the inpatient multi-disciplinary team work together has been changed so that there is a daily morning meeting for all, with a focus on recovery. Again, if R had been admitted in 2014 there may have been more opportunity to discuss his situation and an earlier recovery-focused plan may have been developed.

9.10 A single comprehensive assessment has been introduced so that a service user should not have to tell their story a number of times, although this will not prevent more specialist assessments taking place when indicated. This is particularly relevant in R's case as he appears to have received three separate assessments on 5 March 2011 prior to his admission to Bridge ward.

Recommendation 10
The Trust should test for effectiveness their implementation of the internal investigation's recommendations, and ensure that the new model of care is operating fully and effectively by conducting some qualitative audits of the whole care pathway including for someone with personality disorder.

[36] *5 Boroughs Partnership NHS Foundation Trust (2013) Adult Services Inpatient Model.*

10. PREDICTABILITYAND PREVENTABILITY OF THIS TRAGIC INCIDENT AND RECOMMENDATIONS

10.1 The Scoping Group of the Royal College of Psychiatrists has observed that: *Risk …. cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.*'[37]

10.2 With due regard to this observation we would like to make the following comments on the predictability and preventability of this homicide.

Predictability

10.3 It is clear that R was, in early 2011, telling staff and others that he felt he would do someone some harm and also that, according to his own reports, he had already hurt others, including his sister. He reported that he felt out of control and likely to 'explode'. It was also clear that the mental health service of Trust 1 responded to R's pleas for help by assessing and providing crisis care in hospital and/or via the crisis resolution and home treatment team. Although the purpose of admissions and crisis team contact was not always clearly identified, there were significant efforts made to establish and maintain contact with him in the community, but little sense of any partnership whereby R co-operated with the teams in his care. In addition, once admitted, R told staff that he was well and no longer experienced any distressing mental health problems. Once discharged he rapidly dropped out of contact despite the efforts of community staff to keep in touch by home visits and telephone calls.

10.4 In the light of R's forensic history, drug misuse and reluctance or inability to engage with the service we believe that it was predictable that there would be further violence of some nature, although there was no history of very serious assault or homicide. The nature and seriousness of any violence was however not predictable. It was not predictable, therefore, that any future violence would result in someone's death.

Preventability

10.5 We conclude that given the information that was available to agencies at the time, and information that the agencies should have known but did not, no action(s) could have been taken that would have either predicted or prevented the incident occurring in April 2011. Although a violent incident of some kind was predictable we believe that the mental health service did all that it could to manage this risk and that therefore the homicide was not preventable.

10.6 However we would like to note that there were several significant missed opportunities where a more detailed and comprehensive assessment of R's presentation and potential risks could have been undertaken. This would have informed decisions regarding his potential risks to others.

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[37] *Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23.*

10.7 We would like to conclude by suggesting that improved risk assessments may only have a limited role in reducing homicides and irrespective of the individual's potential risk of harm, either to themselves or others, that such incidents may be more preventable if there are more integrated and responsive mental health care services available.

Recommendations

The independent investigation fully endorses the recommendations of the internal investigation and, we have therefore not repeated them in our recommendations. The following are the recommendations arising from this independent review.

All of the recommendations set out in this report relate to 5 Boroughs Partnership NHS Foundation Trust (Trust 1). However recommendations 5 and 6 will also be of relevance to Mersey Care NHS Trust (Trust 2).

1. The Trust should provide training and develop guidance to ensure that there is a greater focus on, and value attached to, the building of a therapeutic relationship between inpatient and community staff and their service users.

2. The Trust should ensure that any reports from service users about violent behaviour are fully logged in the patient's notes and reported in detail to the police.

3. The Trust should ensure that, when there are reports of actual or possible violence, a detailed history is compiled and an appropriate risk assessment tool is used.

4. The Trust should ensure that their risk management strategy outlines a clear link between risk assessment, care planning, care co-ordination and the application of CPA.

5. The Trust should ensure that any requests for a specific medication are fully explored with the service user and the possibility of dependency is considered and discussed.

6. The Trust should consider whether, when a service user is known to have a particularly peripatetic lifestyle and there are significant concerns about risk, contact should be made with appropriate mental health trusts to share information (with due regard to guidance on confidentiality).

7. The Trust should ensure that, when there has been reported violence to a family member, there should be robust efforts to establish some contact with the victim and other family members to discuss the issue, and to consider an assessment of carers' needs, in line with Trust 1's CPA policy.

8. The Trust should review progress made against the internal review's recommendation for mental health staff to assist service users to register with a local GP, and establish systems for effective communication between GPs and mental health services regarding patient care.

9. The Trust should revise their drug detection policy to include procedures around the use of drug detection dogs, and specifically a process for making service users aware that drug detection dogs may visit acute inpatient areas.

10. The Trust should test for effectiveness their implementation of the internal investigation's recommendations, and ensure that the new model of care is operating fully and effectively by conducting some qualitative audits of the whole care pathway including for someone with personality disorder.

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APPENDIX A

PURPOSE AND TERMS OF REFERENCE OF THE INVESTIGATION

The purpose of independent investigations has been described in NHS England's operating model. Independent investigations are set up to examine the care and treatment of certain patients and establish whether or not a homicide could have been predicted or prevented and if any lessons can be learned for the future to reduce the chances of reoccurrence of a similar incident. Trusts will also be expected to implement any recommendations and action plans arising from the report. Further, the reports of independent investigations are shared with other providers and commissioners so that they take account of the lessons learnt and take steps to reduce the chances of similar incidents occurring in their own services.[38]
5 Boroughs Trust was identified by NHS England as the lead organisation for this particular investigation.

The terms of reference of this investigation
Review the trust's internal investigation and assess the adequacy of the findings, recommendations and action plan.
Review the progress that the trust has made in implementing the action plan.

Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from R's first contact with services to the time of his offence, with a particular focus on the six-twelve months prior to the offence.

Review the appropriateness of R's treatment in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.

Review the adequacy of risk assessments and risk management, including specifically the risk of R harming himself or others.

Examine the effectiveness of R's care plan including the involvement of himself and his family.

Review any safeguarding issues arising in the course of R's care and treatment

Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with victim support, police and other support organisations.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Consider if this incident was either predictable or preventable.

Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
Assist NHS England in undertaking a brief post investigation evaluation.

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[38] *NHS England, April 2013. Delivering a Single Operating Model for investigating mental health homicides for the NHS in England*

APPENDIX B - Chronology of care and treatment

This chronology of R' care and treatment has been drawn up from medical records

Date	
23/2/04	Contact with Ravenscourt CMHT having been referred by his GP for help with his temper and violent attacks.
16/3/04	Seen by SHO in out-patients in Central CMHT.
14/3/05	Contact with Montgomery CMHT
28/12/05	Letter from Trust 1 consultant asking Trust 2 consultant to take over his care.
January – April 2006	A number of offered appointments with no response
11/4/06	Discharged from Montgomery CMHT after non-attendance
1/6/6-6/6/6	Admission to Coniston ward
26/06/06	Sentenced to prison for 4 years and 3 months for burglary and assault on partner and child (prior to admission to Coniston ward)
29/06/06	Referral to prison CMHT with panic and possible drug induced psychosis. Later referred to primary care and dual diagnosis teams.
May 08	Released from prison without medication
28/8/08 – 05/09/08	Admission to Coniston unit
3/10/08	Seen by Knowsley and St Helens criminal justice team. Said he was fine and did not want any input from psychiatric services. Planned to move to Liverpool to look after sister.
7/10/08	Knowsley & St Helens criminal justice team contacted Liverpool criminal justice team to pass on SJ's details as he was moving to Liverpool.
15/09/09	Referral to drug rehabilitation requirements team for 12 months supervision and nine month DRR. Very comprehensive drugs history and assessment. Significant drug use including heroin (IV), crack and cocaine. Methadone prescription. Further appointments and drug testing, which revealed continuing cocaine and crack use.
17/12/09	Discharged from Liverpool DRR team as now living in Birkenhead. Care transferred to Birkenhead service (Wirral Arch).
25/2/10	Following short prison sentence moved back to Liverpool and referred back to Liverpool drug service. Re-prescribed methadone, having had it in prison.
27/3/10	Did not attend a series of appointments. Probation informed that he was in breach of his DRR order. Discharged from service.
21/05/10	Criminal justice liaison team requested by police custody to attend and assess R who was drunk and claiming to be schizophrenic.

6/6/10	Presented at Whiston Hospital A&E, saying he felt he would explode and could hurt himself or others. Seen by CRHT and admitted to Bridge ward. Asked to be prescribed quetiapine saying it was the only drug which worked. Initially concerned with dosage of Zopiclone, saying it was too low.
6/6/10	Assessed by psychiatrist. The following risk assessment was made: Risk to self (suicide/DSH) moderate to high Risk to others → high due to violent thoughts and past history of assaults. Risk screening also carried out. Risk to self and risk to others both assessed as likely to occur.
7/6/10	Contact made by Bridge ward staff with his probation officer and drugs worker. Told that he had come out of prison on 25/2/10 and would have had two weeks of quetiapine (often prescribed as a sedative to help methadone users in prison). Repeatedly told staff that he felt his 'head would explode', and that quetiapine was the only medication which worked.
8/6/10	Transferred to Coniston ward
10/6/10	Multi-disciplinary review. Discharge plans discussed.
11/6/10	Discharged from Coniston ward to mother's address. To be followed up by Knowsley CRHT – requested on a fax form on day of discharge.
12/6/10	Two unannounced home visits to arrange seven day follow up. No answer at home address.
13/6/10 and 14/6/10	Three home visits. No answer at home address. Card left, asking him to contact team. Telephone conversation with R . He said he was to be in court over next two days. Arrangement for visit on 16/6/10
16/6/10	No answer on home visit by members of CRHT.
16/6/10	Given a second drug rehabilitation requirements order for 12 months.
21/06/10	DRR care plan started with Liverpool drug service.
24/6/10	Breach of 7 day follow up target. Incident form completed. Case to be closed to CRHT and secondary services.
28/6/10	Member of staff from Drug Rehabilitation Requirements attended for three way meeting with SS and probation. R very distressed as he had just heard that his 15 month old son was to be adopted. At that time R was on a DRR order. The plan was to refer him for detox and rehabilitation once he had a negative cocaine result.
15/07/10	He was reviewed by the staff grade psychiatrist and two further members of Liverpool Drug Intervention Programme (DIP[39]) team. The plan was to increase his

[39] The Drug Intervention Programme was a department within the Liverpool Criminal Justice Liaison Team. In 2003 the Home Office set up DIP schemes to use the criminal justice system as a means to enable offenders

	methadone prescription and for him to see his GP (although not registered) for psychotropic medication and to contact the crisis team at RLUH if needed. Later that day R contacted mental heath crisis line RLUH. He told the member of staff he had been in Whiston Hospital recently and been prescribed quetiapine and citalopram, but did not have any more as he was no longer registered with a GP. Explained that he would have to register with a GP from his new address.
9/8/10	He presented at A&E at RLUH saying he had had a psychotic episode and reported auditory and visual hallucinations. He was to be assessed by a mental health practitioner but did not stay in the department for assessment. During this time he was living in a hostel.
11/8/10-17/8/10	Extremely chaotic period with a number of missed appointments, drug taking and requests for prescribed medication.
18/8/10	Community pharmacist contacted DRR team to say he was concerned about R's mental health and had advised him to attend crisis team.
19/08/10	Attempted telephone contact from DRR team to Coniston ward with no answer. Had registered with GP who prescribed anti-depressants and anti-psychotics, but GP was very concerned about his mental health and wanted him seen quickly. It appears that he was assessed by SHO at A&E at RLUH and admission was agreed to Park unit (an acute inpatient ward run by Trust 2 which covers the Sefton area) as no beds available in Liverpool.
23/08/10	Discharged from Park unit and followed up by the CRHT and drug teams.
24/08/10	Risk assessment and management plan completed. The care/management plan included team visits to his home every second day in the first instance. Risk to self assessed as low Risk of self neglect – low to moderate Risk to others – low. (Said that he would not act on his thoughts about harming others.)
2/9/10 & 6/9/10	A number of missed appointments with crisis team and drugs workers. Discharged from Trust 2 mental health service.
6/9/10	R attended A&E stating that he had taken an overdose of 16 citalopram, 6 seroquel and a number of mirtazapine.

address their drug misuse, at the same time as ensuring they were closely managed and connected to other services in order to reduce drug related offending.

	(Blood results were reported as normal.) He also said he felt very depressed and was hearing voices telling him to hurt people and self-harm. Assessed by mental health practitioner. He told her that he had assaulted three strangers in the street over the past week and was scared that he may kill someone. Further assessment the following morning. Assessed as not psychotic or depressed and not admitted, but to be followed up by community team.
10/09/10	R went into prison for burglary.
9/11/10	Released from prison
10/11/10	Attended drug service. Told drug worker that he now lived in the Bootle area and will sign on with a new GP. Transferred to Sefton DRR (Dug Rehabilitation Requirements[40]) team. Referral faxed to the CRI team and letter sent to GP.
16/11/10	Final appointment with Liverpool DRR team. Said that he had been using heroin as 'had lost script last week'. Advised to ensure attendance at Sefton DRR team the next day. Case closed at Liverpool DRR team.
29/1/11	R presented at Whiston Hospital A&E saying that he had violent thoughts that he would hurt someone, and that his heart was pounding. It was known that he had previous admissions and diagnosis of anxiety and personality disorder. Assessed by St Helens CRHT staff member and SHO. Said that his brother had been shot and his mother's house petrol bombed in the past. Plan was to admit to stabilise mental state and re-start medication, but no bed available. Therefore plan for daily monitoring by CRHT team of mental state and risks. Citalopram may be started straight away, but quetiapine would need to be titrated and he would need to be registered with a GP. SHO's assessment was a moderate risk of harm to self and low risk of harm to others. Risk screening completed and it was judged that there was no likelihood of risk to himself or others occurring.
30/1/11	Member of CRHT explained the prescribing situation to him on home visit, but he became very angry, said that the citalopram did not work, and that he would not engage with team and asked them to leave.
31/1/11	Letter hand delivered to R asking him to make a new appointment with the team.
2/2/11	Medication collected from the pharmacy and two members of CRHT visited his home three times to deliver

[40] *Drug Rehabilitation Requirement (DRR)*
These are part of a community sentence. They are a key way for offenders to address problem drug use and how it affects them and others. A DRR lasts between six months and three years.

	it with no success. In the evening the television and lights were on, but no answer at the door.
3/2/11	Home visit by two members of CHRT team. R opened the door and let them in. Initially very angry but later calmed down. He told them the citalopram did not work and they said they would find out why he had not been prescribed quetiapine.
4/2/11	Home visit by members of CRHT. They had arranged to phone his mobile before knocking on the door. However no answer on the mobile and no response when they knocked on the door.
14/2/11	Note on file to say that R had not responded to letter sent and had not engaged with the service. Therefore he was to be discharged back to his GP.
5/3/11 20.20 hrs	Presented at Whiston Hospital A&E. Seen by Specialist Registrar complaining of PTSD and split personality. Said he had felt unwell for four months. Last contact with mental health services three weeks ago. Intrusive thoughts about harming others. Said he strangled his sister until she passed out yesterday. He had had no medication since leaving prison in November 2010. Said he was tee-total and no current drug use. Doctor's impression was 'acute on chronic mental health problem' – risk to others.
5/3/11 11.40 hrs	Seen by SHO and CPN Said that mental health had deteriorated over past few weeks. Said that he is 'like an animal and would attack anyone on minor things.' Again reported that he had strangled his sister. Denied any hallucinations. Diagnosis was 'worsening of psychosis, non-compliance with medication. High risk of harm to self or others'. Also noted that he appeared to have presented to A&E in order to gain hospital admission and would benefit from assessment.
06/03/11	Comprehensive assessment completed by nurse practitioner in CRHT team. Reported that he said his mental state had deteriorated since leaving prison in Nov 2010. Accepted little responsibility for not having his medication. Said he could 'snap and kill anyone by battering them with a hammer'. In the plan it is noted that the police were informed of threats towards others.
6/3/11 06.00 hrs	Admitted to Bridge ward (a ward in Halton for men), from Whiston A&E (where he had self referred). Diagnosis on admission particulars: anxiety and depression personality disorder Put on level 2 observations and started on quetiapine and citalopram. Said that he had not been taking his medication since released from prison in Nov 10, as he had no GP. Denied recent alcohol or illicit substance use, but said that

	he had taken cocaine, cannabis and ecstasy in the past. Currently unemployed.
6/3/11 10.35 hrs	Said that he had been taking heroin, methadone and cocaine approximately six months ago. He reported his mood as low, but objectively appeared euthymic. On level 2, 15 minute observations. HoNOS partially completed. Risk assessment and summary completed. Assessed as LOW for risk of violence and aggression.
6/3/11 pm	Approached staff to ask if he would be starting his medication tonight, and said that as long as he received it that night he would be OK.
7/3/11 am	72 hr post-admission review. Appeared calmer and no obvious sign of agitation. No evidence of psychosis, depression or anxiety. Said he needs medication to calm him down, and said that if he did not get it he would 'kick off'. Drug screen was positive for cocaine. Keen to have psychological assessment. Possible diagnosis of personality disorder, antisocial type. Plan to consider referral to personality disorder hub, and to transfer to a local hospital.
7/3/11 pm	Transferred to Coniston unit (a ward in Knowsley for men). Provisional plan to ask community team to review for discharge. Continues to be on level 2, 15 minutes observations.
8/3/11 – 9/3/11	Spent time with other patients, laughing and joking. No signs of psychosis. Asked to be allocated a CPN. Remained on level 2, 15 minute observations. A further drug screen on 9/3/11 was positive for cocaine. Noted by nurse that he presented no reason to be an inpatient.
10/3/11	Met CPN, who had agreed to take on care co-ordinator role.
10/3/11	Multi-disciplinary review. Said that he had taken cocaine and methadone recently. Also said he would return to his mother's house. Told CPN that his brain was too active and he had sick thoughts of wanting to hurt others. Noted in the review record that he had appeared relaxed since admission, and that there were no thoughts of self harm or harm to others. Plan: Continue medication Referral to personality disorder hub Staff to use CBT principles Can have leave off the ward, with staff having high index of suspicion about drugs Aim for discharge Monday or Tuesday (ie 14 or 15 March) CPN to contact mother to check history and enquire about alleged assault on sister

11/3/11	Remained pleasant, interacting with other patients. Had a visit from members of his family. It appears that he was on general observations.
12/3/11	Went off the ward with visitors at 2 pm. No record of when he returned to the ward.
13/3/11	Stayed in his room throughout the morning and appears not to have eaten breakfast or lunch. Recorded in notes that he later returned from leave at 9pm.
14/3/11	Attended an OT group which was a sports quiz. He participated fully and appeared to enjoy it.
15/3/11 am	Spent much of the day in his room, in bed. Noted by staff that there was no reason for him to be on acute inpatient ward, and that a review should be arranged to discuss discharge.
15/3/11	During the afternoon a meeting was held with all patients to say that 'no leave would be allowed for informal patients' as the drug detection dogs would be on the ward. R became verbally abusive, and de-escalation was needed. He was then heard on the telephone and then asked to take his own discharge. He refused to wait to see the doctor. Risk screening completed. The screen recorded the following factors which could be relevant in the risk of harm to others: History of attempting or succeeding in harming others Evidence that family members may be in danger from him Feeling of hopelessness/helplessness History of non-concordance with medication History of disengaging from services At risk if loses contact with services It was judged that there was a likelihood of risk occurring to himself and to others.
15/3/11 7pm	Discharged himself against medical advice. No medication provided.
15/3/11	CPN from Montgomery Road CMHT recorded that he was called in for review in light of planned imminent discharge, but this was pre-empted by R taking own discharge.
16/3/11	CPN and team manager agree to await Home treatment /crisis team assessment.
17/3/11	Home visit by members of CRHT team. He appeared slightly suspicious but pleasant. Said he had no medication. Team said they would check for any medication on Coniston and asked him to register with a GP. Agreed that they would visit the next day.
18/3/11	Home visit by members of CRHT team. Two telephone calls were unanswered and he did not answer the door when they visited.
20/3/11	CRHT team member made telephone contact with his mother. R not available to talk but she would give him a message, asking him to contact team the next day.

22/3/11	Team discussion. Noted that 7 day follow up had been completed, but no further contact since 17/3/11. Agreed that his case would be closed to both the CRHT and to Montgomery Road CMHT.
29/3/11	Email correspondence between member of Coniston ward staff and Montgomery CMHT about the possibility of the CMHT referring to the personality disorder hub. This email was sent on to a practitioner in the PD hub with a request for a discussion.
11/4/11	Letter sent to R with an appointment for 19/4/11 to see the dual diagnosis practitioner/CPN.
13/4/11	Letter sent to Abercromby Health Centre about the A&E assessment on 30/1/11. Returned to the trust with a note to say he was not their patient.
18/4/11	Letter from the CMHT manager saying that he had not attended the appointment and he could ask his GP to refer him again if he wished.
17/04/11	Homicide in very early hours of the morning
20/04/11	Assessed in custody by Trust 2 Criminal Justice Liaison team. Did not require diversion.
	No further contact until the involvement of the Criminal Justice Liaison team on 27/4/11 following the homicide.

APPENDIX C

Best practice in addressing dual diagnosis of personality disorder and substance misuse[41]

Commissioners and trusts should ensure that:

- staff in drug and alcohol teams are trained in the recognition and assessment of PD
- staff in PD services are trained in the recognition and assessment of substance misuse/dependence
- joint ongoing supervision is provided between substance misuse and specialist PD services
- dual diagnosis staff across all services are provided with training and supervision in the recognition and treatment of PD
- shared care protocols are established so that reduction in substance misuse is undertaken simultaneously with the provision of psychological treatment for PD to allow for the best chance of a successful outcome
- shared care protocols include jointly agreed responses to relapse and to risk, clear goals for each treatment/service, and regular and good quality communication
- specialist PD services, drug and alcohol teams, and all mental health front-line staff working with PD and substance misuse receive training in motivation enhancement (Motivational Interviewing) techniques
- services for PD and substance misuse provide advice and support for attending harm minimisation and sexual health clinics to reduce the risk of blood-borne viruses
- intervention programmes provide information and support on returning to education as a means of eventually engaging in vocational activity.
- The recommendations apply to services provided in the community for less severe PD, to secure settings for PD, and to services provided within the prison system for PD and substance-misusing offenders

[41] *Dept of Health. Recognising complexity: Commissioning guidance for personality disorder services. June 2009*

APPENDIX D. Trust 1's action plan

Recommendation *Copy from the report*	Action *Specify what you are going to do in order to implement the recommendations*	Date for action to be achieved or reviewed	Owner	Outcome (evidence)
Local Actions				
Practitioners should be reminded of the obligation to inform and update the Safeguarding Children's Unit each time a patient with a previously recorded referral to the Safeguarding Unit. Re-enters services.	Communication to all Managers and an agenda at Local QPR meeting	Immediate	Operational Business Manager	Minutes of QPR attached. 19 10 11 Communications meet
Practitioners of patients in the community should take a more active role in helping individual patients secure a general practitioner	Communication to all Managers – reference Integrated Care Pathway Document. Agenda at Local QPR meeting	Immediate	Operational Business Manager	Minutes of QPR attached 19 10 11 Communications meet
There is a need to improve the ward staff awareness of drug services available to them in the local community	Dual Diagnosis Practitioners to circulate Information re Local Services	Immediate	Operational Business Manager / Dual Diagnosis Practitioner	Information is now displayed for staff and service users on the wards in a poster format.
Trust wide Actions				
The Trust should examine the clinical value of HoNOS and reconsider the decision not to make HoNOS available on Otter.	The Otter Steering Group to reconsider the decision not to make HoNOS available on Otter	December 2011	Assistant Director Informatics	Has been discussed at the steering group meeting, it was decided that HoNOS would not be added to Otter as there is to be a new electronic patient system.
The trust should introduce a specific	The current training in HCR 20 to be extended	Completed	Assistant Director	Evidence of

risk assessment tool for the assessment of risk of violence and aggression/harm to others	where clinically appropriate and the tool accepted as a tool available to all clinicians. Policies and procedures for assessment to be adapted accordingly		Forensic and Learning Disability Services	training  Copy of HCR 20 training 140404.xls
Both trusts to engage with HMP Liverpool to explore ways to improve the communication and information sharing between them	Further establish the engagement that exists with HMP Liverpool by St. Helens and Knowsley CJLT to improve future communication from the prison and agree protocols for doing so	December 2011	Operational Business Manager / Criminal Justice Liaison Practitioner	The CJLT attend a regular monthly meeting which is held at HMP Liverpool for purposes of improved communication and joint working.  CJS operational guidelines11 13 (2) (3
The trust should consider current inconsistencies of understanding and practice regarding the role and responsibilities of the 'named nurse'.	Due to the changes proposed within the Acute Care Pathway, there will need to be specific guidelines developed for inpatient services which will need to consider this recommendation. N.B Guidelines for inpatient services are currently integrated with CRHT	June 2012		Guidelines attached.  Named Nurse Guidelines V6 final.doc

APPENDIX E

PROFILE OF THE TWO TRUSTS

5 Boroughs Partnership NHS Foundation Trust

This trust provides mental health, learning disability and community health services across a footprint of 5 geographical boroughs, Warrington, Wigan, St. Helens and Knowsley and Halton. The provision of community healthcare for physical health problems in the borough of Knowsley is an additional service; it was not managed by 5BP in 2011.

In 2011 drug and alcohol services were provided by independent organisations; for St. Helens and Knowsley drug and alcohol services were provided by Addaction, a charitable organisation. The service was commissioned by Public Health Commissioning at St. Helens Council. The same arrangements are in place currently.

In 2011 the main adult mental health service provision in St. Helens and Knowsley would have been via Community Mental Health Teams (CMHTs), Crisis Resolution Home Treatment or inpatient beds at Whiston Hospital. Other supplementary services such as the Personality Disorder Hub and psychological services existed as a trust wide service.

All services were reviewed in 2013 and were reorganised on a recovery model known as the Acute Care Pathway. In patient services in St. Helens and Knowsley continues to be provided on site at Whiston hospital, known as the Knowsley Recovery Centre where there is a single mixed inpatient acute ward.
The Home Treatment Team, based in Knowsley, provides a seven day per week intensive home treatment service as an alternative to admission and provides follow up to newly discharged patients.

Recovery Teams replaced the old CMHTs; they provide community care on a Monday to Friday 9am to 5pm basis.

A 24/7 Psychiatric Liaison Team is based in Whiston Hospital Accident and Emergency Department, providing an assessment of mental health needs to all adults age 16 to 65.

Mersey Care NHS Trust

Services offered for the treatment and support of patients/service users are provided within Mersey Care based on service speciality and/or geographical location. Local services are commissioned for the people of Liverpool, Sefton and Kirkby, in addition to medium secure services for the residents of Cheshire and Merseyside and high secure services provided nationally.

Local Services

Local services provide mental health services and care to adults in Liverpool. Services include acute inpatient care, accident and emergency liaison, crisis teams, community mental health teams, assertive outreach, early intervention in psychosis, homeless outreach and psychology. A gateway system ensures that people are referred to the most appropriate service for their needs.

Similar services are provided in Sefton, Kirkby and North Liverpool to adults and older people and acute care inpatients. Other services include: accident and emergency liaison, crisis and gateway services, community mental health teams, assertive outreach and early intervention in psychosis and psychology. They provide assessment and/or treatment for people experiencing mental health difficulties. The aim is to deliver care that respects individuals, values diversity, preserves dignity and promotes recovery and inclusion.

Addiction services provide drugs and alcohol services for the population of Liverpool, Sefton and Kirkby, from Windsor Clinic and the Kevin White Unit. Community services are also provided. In general, addiction services provide care and treatment for people suffering from alcohol or drug dependency and offer a range of care pathways and individually tailored therapeutic programmes within both residential and community settings. These are delivered by a consultant-led multi-disciplinary staff group.

Services are provided for clients with learning disabilities, including community residential services, community teams, inpatient services, respite services, on call service and the Asperger's service.

The rehabilitation unit focuses the team's approach to rehabilitation on one that encompasses recovery, minimises hospital stay and facilitates early return to appropriate settings.

Forensic services
There are a large number of forensic and secure services including the following: the criminal justice liaison team is a court based mental health liaison service addressing the needs of mentally disordered offenders at points of the criminal justice system.

The prison health liaison team provides secondary mental health services into HMP Liverpool in Walton, and the prison based primary care psychological service provides a range of psychological interventions to offenders.